DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 13047 (Rev. 08/05)

STATE OF WISCONSIN

WISCONSIN MEDICAID
TIMELY FILING APPEALS REQUEST

Instructions: Type or print clearly.

The attached claim / adjustment meets one or more of the following criteria that are considered for late processing approval (check the appropriate statement[s]):

❑ Claim(s) denied for an eligibility-related explanation of benefits (EOB), reason, remark, or National Council for Prescription Drug Programs (NCPDP) reject code.
Claim number / payer claim control number, _____, originally processed on the Remittance and Status (R/S) Report or the 835 Health Care Claim Payment / Advice (835) transaction number _____, with the R/S Report / check issue date of _____ (attach R/S Report, if available, and one of the following items documenting eligibility: a copy of the magnetic stripe card reader printout, Automated Voice Response log number, or a copy of a paper temporary or Presumptive Eligibility card).

❑ Nursing home level of care / liability amount changes.
Claim number / payer claim control number, _____, originally processed on R/S Report or the 835 transaction number _____, with the R/S Report / check issue date of _____ (R/S Report attached, if available).
New level of care _____.
New liability amount _____.

❑ Retroactive recipient eligibility for Wisconsin Medicaid (attach appropriate documentation for retroactive period, if available).

❑ Retroactive eligibility for general relief.

❑ Other insurance / Medicare recoupment (recoupment dated _____ attached).

❑ Medicare denial or reconsideration (reconsideration date _____ attached).

❑ Medicaid reconsideration.
Claim number / payer claim control number, _____, originally processed on R/S Report or the 835 transaction number _____, with the R/S Report / check issue date of _____ (R/S Report attached, if available).

❑ Fair hearing decision, with signature dated _____ (complete copy attached).

❑ Court order, with signature dated _____ (complete copy attached).

Briefly explain the nature of the problem and previous efforts made to resolve the claims.

SIGNATURE — Provider	Date Signed

Continued

Reset Form

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form. If necessary, attach additional pages if more space is needed. Refer to the Claims Submission section of the All-Provider Handbook and the applicable service-specific handbook for service restrictions and additional documentation requirements.

Attach the completed Timely Filing Appeals Request to the claim or adjustment form and attachments and submit them to Wisconsin Medicaid at the following address:

Wisconsin Medicaid
Timely Filing
Ste 50
6406 Bridge Rd
Madison WI 53784-0050